Virginia Department of Medical Assistance Services

837 Institutional Encounters
Data Clarification
for
Managed Care Organizations

ASC X12N 837
Version 004010X096A1

Version 1.0
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Version Change Summary

Version No.	Description	Date
Version 1.0	Original Implementation	03/22/2006

INTRODUCTION

This document is a companion to the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional, ASC X12N 837 dated May 2000 (IG) and the Addenda dated October 2002 (004010X096A1). The 837 IG and Addenda are available from the Washington Publishing Company and may be downloaded from www.wpc-edi.com/hipaa/.

DMAS intends that this clarification document be used in conjunction with the IG and Addenda, which contain all of the Health Insurance Portability and Accountability Act (HIPAA) transaction and code set requirements. This document supplements the IG and Addenda with data clarifications that are authorized under HIPAA. It is provided to clarify situations where the IG is not specific and to help the MCO understand how DMAS will be using the inbound 837 transactions and its data elements in the Virginia Medicaid Management Information System (VaMMIS).

PURPOSE

The purpose of this clarification is to outline DMAS's specific requirements with respect to the 837 data loops, segments, and elements for encounter data. The goal is to facilitate the contracted MCO's understanding of DMAS's data needs.

Facility claims and encounter data submitted to DMAS using the 837 transactions should follow the Provider-to-Provider-to-Payer COB data model referenced in the IG (see page 15 of the guide for information about this model). This model contains loops, segments, and data elements that provide information necessary for DMAS's MMIS and decision support systems.

Page numbers on the following data-clarification matrix refer to the page number in the IG on which the data element appears. Page numbers that begin with "A" are Addenda page numbers. Page numbers that begin with "B" are from Appendix B of the IG, EDI Control Directory.

All data elements that are used by the VaMMIS are listed on the following matrix. The matrix does **not** include all data elements that are required by the IG and those must be coded according to instructions in the IG. The instructions here are not intended to override instructions or requirements contained in the IG; they are provided to clarify DMAS's expectations with respect to the various data elements within the 837 transaction where interpretation is possible.

Not all data elements that are indicated as used on the following matrix are required in every situation. Some of the data elements indicated as used are required only when a specific situation is present. For example, inpatient facility claims require an admission date and hour; it is not required on outpatient facility claims. Likewise, outpatient facility claims require a HCPCS procedure at the service line level if available, but these are not coded for inpatient facility services.

If the MCO is submitting both claims to be paid by DMAS and encounters for services rendered and paid under DMAS's capitation agreement with the MCO, these must be submitted in separate ISA-IEA envelopes.

REQUIRED ENCOUNTER DATA

All encounters processed by the MCO or any MCO subcontracted vendor should be submitted to DMAS in the prescribed format, including records that were denied for most reasons.

The exceptions, which should NOT be submitted to DMAS, are:

- Encounters that are rejected by the MCO
- Encounters that are duplicates of records previously submitted by the provider
- Encounters that contain an invalid Medicaid recipient identifier
- Encounters for Medicaid recipients who are not enrolled with your MCO

If the encounter being submitted is one that you have denied, the encounter should be submitted to DMAS with the appropriate denial reason code from the Adjustment Reason Code set (code source 139) appearing in the first CAS segment of the encounter.

ADJUSTMENTS and VOIDS

When submitting adjustment or void records, please ensure the adjusted or void record conform to the following requirements:

1. If the record to which the adjustment applies was not previously submitted to VaMMIS, the original record must precede the adjustment record in the file containing the adjustment record. In other words, you can submit an original and adjustment record in the same file as long as the original record precedes the adjustment record.

2. Your claim number on the original record must be coded in Loop 2300, REF segment (page 180 of IG), REF02 – Original Reference Number. If this number does not match a number in the DMAS system, the adjustment or void record will be assigned a fatal error code.

3. If you are adjusting or voiding one service line on a claim that has more than one line, you must adjust or void all lines. The order in which the service lines appear on an adjusted or voided claim must be the same as on the original claim.

NATIONAL PROVIDER IDENTIFIER

The final rule on National Provider Identifiers (NPI) becomes effective on May 23, 2007 (except for small health plans, which have until May 23, 2008). The final rule specifies that a covered provider must use its assigned NPI where called for on all HIPAA-

specified electronic transactions exchanged between covered entities beginning on May 23, 2007 (or May 23, 2008 for small plans).

In order to prepare for compliance with the NPI rule, DMAS will implement its use of the NPI in phases as follows:

Phase 1: Effective immediately, DMAS will accept both legacy ID (current nine-digit Medicaid provider ID) and the NPI but only the legacy number will be used in the VaMMIS.

Phase 2: Effective 2/17/2007 DMAS will accept both the legacy ID and the NPI. However, if an NPI is present, only the NPI number will be used.

Phase 3: Effective 5/23/2007, DMAS will only accept the NPI. Legacy IDs will be returned as invalid.

For providers that are not considered health care providers and cannot obtain an NPI (such as taxi drivers), DMAS is developing a plan to provide those providers with a ten-digit ID that will mimic the NPI.

DMAS DOCUMENTATION

To further assist MCOs in the encounter data submission process, DMAS is providing other information that MCOs should review. These documents include:

- Encounter Data Submission Manual at https://virginia.fhsc.com/providers/Manuals.asp
- Companion Guides at https://virginia.fhsc.com/hipaa/CompanionGuides.asp
- Data Clarifications at http://www.dmas.virginia.gov/mc-encounter.htm

The Companion Guides are not specific to encounter data, but may contain helpful information not found in the Data Clarifications or this Encounter Data Submission Manual.

Virginia Department of Medical Assistance Services
Data Clarification – 837 Institutional Transactions
for
Managed Care Organizations

Page	Loop	Segment	Data Element	Clarification
B.3		ISA	ISA01 – Authorization Information Qualifier	Use "00"
B.3		ISA	ISA02 – Authorization Information	Use ten blanks
B.4		ISA	ISA03 – Security Information Qualifier	Use "00"
B.4		ISA	ISA04 – Security Information	Use ten blanks
B.4		ISA	ISA05 – Interchange ID Qualifier	Use "ZZ"
B.4		ISA	ISA06 – Interchange Sender ID	Use the MCOs four-digit Service Center Number assigned by First Health
B.4		ISA	ISA07 – Interchange ID Qualifier	Use "ZZ"
B.5		ISA	ISA08 – Interchange Receiver ID	Use "VMAP FHSC FA"
B.5		ISA	ISA09 – Interchange Date	YYMMDD of interchange
B.5		ISA	ISA10 – Interchange Time	HHMM of interchange
B.5		ISA	ISA11 – Interchange Control Standards Identifier	Use "U"
B.5		ISA	ISA12 – Interchange Control Version Number	Use "00401"
B.5		ISA	ISA13 – Interchange Control Number	Nine-digit control number assigned by sender. Must match the value in IEA02.

Page	Loop	Segment	Data Element	Clarification
B.6		ISA	ISA14 – Acknowledgment Requested	Use “0”
B.6		ISA	ISA15 – Usage Indicator	Use “P” for production data or “T” for test data
B.6		ISA	ISA16 – Component Element Separator	Use “>”
B.8		GS	GS01 – Functional Identifier Code	Use “HC”
B.8		GS	GS02 – Application Sender’s Code	Use the MCOs four-digit Service Center Number assigned by First Health
B.8		GS	GS03 – Application Receiver’s Code	Use “VMAP FHSC FA”
B.8		GS	GS04 – Functional Group Creation Date	CCYYMMDD
B.8		GS	GS05 – Creation Time	HHMM
B.9		GS	GS06 – Group Control Number	Assigned by the MCO. Must be identical to the associated functional group trailer, GE02.
B.9		GS	GS07 – Responsible Agency Code	Use “X”
B.9		GS	GS08 – Version/Release/ Industry Identifier Code	Use “004010X096A1”
56		ST	ST01 – Transaction Set Identifier Code	Use “837”
56		ST	ST02 – Transaction Set Control Number	Use a number that is unique within the functional group and interchange (GS-GE and ISA-IEA). Must be identical to SE02.
57		BHT	BHT01 – Hierarchical Structure Code	Use “0019”
58		BHT	BHT02 – Transaction Set Purpose Code	Use “00” if original submission; use “18’ if the file is being resubmitted.

Page	Loop	Segment	Data Element	Clarification
58		BHT	BHT03 – Originator Application Transaction Identifier	Specific to the MCO – this will operate as the batch control number.
58		BHT	BHT04 – Creation Date	CCYYMMDD
58		BHT	BHT05 – Creation Time	HHMM
59		BHT	BHT06 - Transaction Type Code	Use "RP" (Reporting)
A11		REF	REF01 – Reference ID Qualifier	Use "87"
A11		REF	REF02 – Transmission Type Code	Use "004010X096A1"
63	1000A	NM1	NM109 – Submitter Primary Identifier	Use the MCO's four-digit Service Center Number assigned by First Health
68	1000B	NM1	NM103 – Last Name or Organization Name	Use "Dept of Med Assist Svcs"
68	1000B	NM1	NM109 – Receiver Primary ID Code	Use "Dept of Med Assist Svcs"
77	2010AA	NM1	NM108 – Identification Code Qualifier	After implementation of the NPI, use "XX", until then use either: 24 = Employer's Identification Number 34 = Social Security Number
78	2010AA	NM1	NM109 – Billing Provider ID	If NM108 is XX, this is the NPI for the provider that is billing for the service (not the MCO's ID). Prior to NPI implementation, use the provider's (not the MCO's) identifier as indicated above.
84	2010AA	REF	REF01 – Reference ID Qualifier	"1D" (Medicaid Provider Number) This segment will not be needed after full implementation of the NPI. In its place the NM1 segment will be used to report the billing provider NPI.
84	2010AA	REF	REF02 – Billing Provider Secondary ID	This is the nine-digit Medicaid ID number of the billing provider. This segment will not be needed after full implementation of the NPI.

Page	Loop	Segment	Data Element	Clarification
96	2000B	HL	None	The number of claims within an ST/SE segment is limited to 5,000 as recommended in the IG.
102	2000B	SBR	SBR01 – Payer Responsibility Sequence Number Code	Use “S” (Secondary) or “T” (Tertiary)
109	2010BA	NM1	NM103 – Subscriber’s Last Name	Report the last name of the subscriber
109	2010BA	NM1	NM104 – Subscriber’s First Name	Report the first name of the subscriber
110	2010BA	NM1	NM108 – Subscriber ID Qualifier	Use “MI” (Member Identification Number)
110	2010BA	NM1	NM109 – Subscriber Primary ID	Use the twelve-digit enrollee ID number assigned by Virginia Medicaid
158	2300	CLM	CLM01 – Patient Control Number	The MCO’s claim reference number
159	2300	CLM	CLM02 – Total Claim Charges	Total claim charge amount
159	2300	CLM	CLM05-1 – Facility Type Code	The first two positions of the Type of Bill Code.
159	2300	CLM	CLM05-2 – Facility Code Qualifier	Use “A”
159	2300	CLM	CLM05-3 – Claim Frequency Type Code	Use the appropriate code as follows: 1 = Original 7 = Replacement 8 = Void
166	2300	DTP	DTP03 – Discharge Hour	HHMM (use 00 for minutes if not available)
168	2300	DTP	DTP03 – Statement From and/or To Date	CCYYMMDD or CCYYMMDD-CCYYMMDD
170	2300	DTP	DTP03 – Admission Date and Time	CCYYMMDDHHMM

Page	Loop	Segment	Data Element	Clarification
171	2300	CL1	CL101 – Admission Type Code	1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 9 = Information Not Available
172	2300	CL1	CL102 – Admission Source Code	See Code Source 230; required on all inpatient admissions
172	2300	CL1	CL103 – Patient Status Code	See Code Source 239
174	2300	PWK	PWK01 – Attachment Report Type Code	See Implementation Guide for valid values
175	2300	PWK	PWK02 – Attachment Transmission Code	See Implementation Guide for valid values
175	2300	PWK	PWK06 – Attachment Control Number	If PWK02 = BM, EL, EM or FX: Maximum of 33 positions with no embedded spaces or special characters, such as slashes, dashes, punctuation, etc. Made up of three separate fields as follows: Positions – Information – Instructions 1 – 20 – Patient Account Number – Left justify, blank fill 21 – 28 – From Date of Service – Use value from first service line; MMDDCCYY 31 – 33 – Sequential control number – Right justified, zero filled The attachment control number should be the same for every attachment associated with a specific claim.

Page	Loop	Segment	Data Element	Clarification
176	2300	CN1	CN101 – Contract Type Code	How the MCO paid its provider for this claim: 01 = DRG 02 = Per Diem 03 = Variable Per Diem 04 = Flat 05 = Capitated 06 = Percent 09 = Other
182	2300	AMT	AMT01 – Amount Qualifier	Use “F5” (Patient Amount Paid)
183	2300	AMT	AMT02 – Patient Amount Paid	Total amount the patient paid on this claim
191	2300	REF	REF01 – Reference Identification Qualifier	Use “F8” (Original Reference Number) if this record is a replacement or void of a previously submitted record (a value of 7 or 8 CLM105-3).
192	2300	REF	REF02 – Claim Original Reference Number	For void or replacement records, the MCO’s original claim number. Note that this should be a maximum of 20 positions.
198	2300	REF	REF01 – Reference Identification Qualifier	If this service received prior authorization, use “G1”
199	2300	REF	REF02 – Prior Authorization Number	The MCO’s prior authorization number, if applicable
228	2300	HI	HI01-1 – Code List Qualifier	Use “BK” (Principal Diagnosis)
228	2300	HI	HI01-2 – Diagnosis Code	ICD-9-CM diagnosis which is the principal cause of the claim
228	2300	HI	HI02-1 – Code List Qualifier	Required on facility admissions; use “BJ” (Admitting Diagnosis)
228	2300	HI	HI02-2 – Diagnosis Code	ICD-9-CM diagnosis which is the patient reason for the admission
229	2300	HI	HI03-1 – Code List Qualifier	If an external cause of injury is known, use “BN” (E-code)
229	2300	HI	HI03-2 – Diagnosis Code	External cause of injury (ICD-9-CM “E” code)
230	2300	HI	HI01-1 – DRG Information	If the claim was paid under a DRG arrangement, use “DR” (Diagnosis Related Group)
230	2300	HI	HI01-2 – DRG Code	The DRG code under which the claim was paid

Page	Loop	Segment	Data Element	Clarification
232-238	2300	HI	HI01-1 to HI08-1 – Diagnosis Code	Use “BF” (Diagnosis) for as many secondary codes as you have to report
232-238	2300	HI	HI01-2 to HI08-2 – Diagnosis Code	Secondary diagnosis codes applicable to the claim
242	2300	HI	HI01-1 – Code List Qualifier	If a surgery was performed during an inpatient admission, use “BR” (ICD-9-CM Principal Procedure)
243	2300	HI	HI01-2 – Principal Procedure Code	The ICD-9-CM procedure code identifying the principal procedure performed
243	2300	HI	HI01-4 – Procedure Date	The date on which the principal procedure was performed
244-255	2300	HI	HI01-1 to HI12-1 – Code List Qualifier	Use “BQ” (ICD-9-CM Procedure Codes)
244-255	2300	HI	HI01-2 to HI12-2 – Additional Procedure Codes	Report as many secondary procedure codes as are applicable to this claim.
244-255	2300	HI	HI01-3 to HI12-3 – Procedure Code Dates	Dates on which additional procedures were performed corresponding to code above.
256-264	2300	HI	HI01-1 to HI10-1 – Code List Qualifier	Use “BI” (Occurrence Span)
256-264	2300	HI	HI01-2 to HI10-2 – Occurrence Span Code	Use values found in code source 132 for Occurrence Span codes
256-264	2300	HI	HI01-4 to HI10-4 – Occurrence Span Associated Dates	Range of dates expressed as CCYYMMDD – CCYYMMDD
267 – 277	2300	HI	HI01-1 to HI10-1 – Code List Qualifier	Use “BH” (Occurrence)
267 – 277	2300	HI	HI01-2 to HI10-2 – Occurrence Code	Use values found in code source 132 for Occurrence codes
267 – 277	2300	HI	HI01-4 to HI10-4 – Occurrence Code Associated Date	Date expressed as CCYYMMDD

Page	Loop	Segment	Data Element	Clarification
280 – 289	2300	HI	HI01-1 to HI12-1 – Code List Qualifier	Use “BE” (Value)
280 – 289	2300	HI	HI01-2 to HI12-2 – Value Code	Use values found in code source 132 for Value codes
280 – 289	2300	HI	HI01-5 to HI12-5 – Value Code Amount	Associated Value code amount
307	2300	QTY	QTY01 – Quantity Qualifier	Use “CA” (Covered, Actual)
307	2300	QTY	QTY02 – Claim Days Count	The number of covered days
307	2300	QTY	QTY01 – Quantity Qualifier	Use “NA” (Non-covered Days)
307	2300	QTY	QTY02 – Claim Days Count	The number of non-covered days
326	2310A	REF	REF01 – Reference Identification Qualifier	Use “1D” (Medicaid Provider Number). This segment will not be needed after full implementation of the NPI. In its place the NM1 segment will be used to report the attending physician NPI.
327	2310A	REF	REF02 – Attending Physician Secondary Identifier	The nine-digit provider identifier assigned by Virginia Medicaid for the attending physician. This segment will not be needed after full implementation of the NPI.
333	2310B	REF	REF01 – Reference Identification Qualifier	Use “1D” (Medicaid Provider Number) This segment will not be needed after full implementation of the NPI. In its place the NM1 segment will be used to report the operating physician NPI.
334	2310B	REF	REF02 – Operating Physician Secondary Identifier	The nine-digit provider identifier assigned by Virginia Medicaid for the operating physician. This segment will not be needed after full implementation of the NPI.
336	2310C	NM1	NM101 – Entity Identifier Code	Use “73” (Other Physician)
340	2310C	REF	REF01 – Reference Identification Qualifier	Use “1D” (Medicaid Provider Number) This segment will not be needed after full implementation of the NPI. In its place, the NM1 segment will be used for the Other Physician NPI.

Page	Loop	Segment	Data Element	Clarification
341	2310C	REF	REF02 – Other Physician Secondary Identifier	The nine-digit provider identifier assigned by Virginia Medicaid for the other physician. This segment will not be needed after full implementation of the NPI.
365	2300	CAS		If you denied this entire claim or made any adjustment at the claim level, use the following 2320 segments. If denials or adjustments were made at the service level, using the corresponding 2430 segments.
367	2320	CAS	CAS02, 05, 08, 11, 14, 17 – Adjustment Reason Codes	Use any denial codes in the first of these segments; if the claim was not denied by the MCO, use he segments needed to balance the transaction.
367	2320	CAS	CAS03, 06, 09, 12, 16, 18 – Adjustment Amount	If the claim was denied, show the entire charge amount as denied; otherwise use the segment amounts as needed to balance the transaction.
371	2320	AMT	AMT02 – Payer Paid Amount	The amount the MCO paid for this claim.
372	2320	AMT	AMT02 – Allowed Amount	The amount the MCO allowed for this claim.
373	2320	AMT	AMT02 – Total Submitted Charged	The amount the provider submitted to the MCO as total charges for this claim.
415	2330B	DTP	DTP- Adjudication or Paid Date	Date expressed in CCYYMMDD format
444	2400	LX	LX01 – Service Line Number	VA Medicaid suggests that the number of service lines on a claim be restricted to 350 or less.
A24	2400	SV2	SV201 – Service Line Revenue Code	HIPAA standards call for a four-digit Revenue Code. If the code is only three digits, it should be right justified with a lead zero.
			SV202 – Service Line Procedure Code	Required on outpatient facility services if an appropriate code exists.
A24	2400	SV2	SV202-1 – Product or Service ID Qualifier	Use “HC”
A24	2400	SV2	SV202-2 – Procedure Code	HCPCS Procedure Code

Page	Loop	Segment	Data Element	Clarification
448	2400	SV2	SV203 – Line Item Charge Amount	If not reported at the claim level, the submitted charge amount for this line item.
448	2400	SV2	SV204 – Unit or Basis for Measurement Code	DA = Days UN = Units
449	2400	SV2	SV205 – Service Unit Count	Number of units or days
449	2400	SV2	SV207 – Service Line Non-Covered Charge Amount	Amount not covered for this line item
A27	2400	DTP	DTP03 – Service Date	If different than the date reported at the claim level
A45	2430	SVD	SVD03 – Service Line Paid Amount	If not reported at the claim level, the service line paid amount.
494	2430	CAS		If the claim was not adjudicated at the claim level, then the information on adjudication should be coded in this segment.
496-501	2430	CAS	CAS02, 05, 08, 11, 14, 17 – Adjustment Reason Codes	Use any denial codes in the first of these segments; if the claim was not denied by the MCO, use he segments needed to balance the transaction.
496-501	2430	CAS	CAS03, 06, 09, 12, 16, 18 – Adjustment Amount	If the claim was denied, show the entire charge amount as denied; otherwise use the segment amounts as needed to balance the transaction.
B.30		SE	SE01 – Number of Included Segments	Total number of segments included in a transaction set, including the ST and SE segments.
B.30		SE	SE02 – Transaction Set Control Number	Must match the control number in ST02.
B.10		GE	GE01 – Number of Transaction Sets Included	Total number of transaction sets included.
B.10		GE	GE02 – Group Control Number	Must be the same number contained in GS06.
B.7		IEA	IEA01- Number of Included Functional Groups	A count of the number of functional groups included in the interchange.

Page	Loop	Segment	Data Element	Clarification
B.7		IEA	IEA02 – Interchange Control Number	Must match the control number in ISA13.